

The Future: Policy Issues Confronting Washington State

ISSUES

Clients with
Co-Occurring
Disorders

Club Drugs
& OxyContin

Criminal
Justice

Drug-Affected
Infants & Children

Methamphetamine

Opiate Substitution
Treatment

From Research
to Practice

Treatment
Completion
and Retention

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Development

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CLIENTS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE-RELATED DISORDERS

The treatment of chemical dependency is both a public policy and clinical issue. Addiction contributes to many lost lives, broken families, and lost dreams. As illustrated throughout this Report, the public health and safety costs of untreated addiction are enormous. The good news is that there are effective treatment modalities that significantly improve health, reduce crime, enhance employment and earnings, and assist in avoidance of more expensive acute and long-term health-related and social costs.

There is a growing awareness that individuals may suffer from both chemical dependency and mental health disorders. When chemical dependency exists along side a co-occurring psychiatric disorder, the difficulties in providing effective treatment increase dramatically. The treatment needs of individuals with co-occurring disorders are complex, and patients often respond poorly when their disorders are treated sequentially. A major challenge is finding the most effective ways, given limited resources, to respond to these multiple needs by treating the whole individual rather than a series of symptoms. With this new awareness, has come an increased commitment to the development of collaborative relationships among state agencies, regional, and county organizations that have historically operated independently of one another.

Emphasis on Training

In 1998, Division of Alcohol and Substance Abuse (DASA) and the Department of Social and Health Services, Mental Health Division (MHD) joined together to develop a 10-Step Plan for increasing collaboration between the chemical dependency and mental health treatment systems for working with patients with co-occurring disorders. Previous accomplishments of the Plan include the development of a definition of co-occurring disorders and the completion of an analysis of the barriers co-occurring clients encounter, in their attempts to access appropriate treatment.

While the majority of the 10-Step Plan's objectives have been accomplished, a significant emphasis within DASA and MHD remains the training of practitioners in the field. In the last 12 months, approximately 2,300 persons have attended training sessions on detection, diagnosis, training, and case management for persons with co-occurring disorders. In addition, the Co-Occurring Interagency Committee (CODIAC) has recently inaugurated a subcommittee that will focus upon best practices in the delivery of co-occurring disorders treatment and may have preliminary findings available for release during the Annual Co-Occurring Disorders Conference in April 2002.

There is growing concern about clients in the correctional system who jointly impact the mental health and chemical dependency systems. In response to this concern, a new CODIAC subcommittee has been formed that will look at and propose changes in procedure and policy regarding provision of services to individuals with co-occurring disorders entering and exiting Washington's jails and prisons. A concerted effort is being made to jointly train professionals who work in mental health, chemical dependency, and corrections to address the needs of the clients they have in common.

Further work remains to be done in implementing the 10-Step Plan. Needs include: setting consistent standards of care; providing fiscal incentives for the development of programs that are effective with the population affected by co-occurring disorders; and decreasing the high recidivism rate for both detoxification and psychiatric hospital admissions for this population. The chemical dependency and mental health fields, as well as policymakers, must continue to work together to remove statutory, fiscal, and philosophical barriers in order to treat this population more effectively.

Dangerously Mentally Ill Offender Program

DASA is now involved in the second year of implementation of the “Dangerously Mentally Ill Offender (DMIO) Program.” The DMIO program is a collaborative effort between DASA, MHD, and the Department of Corrections. The program was created by legislation enacted in 1999 and is intended to help improve public safety and provide additional treatment for dangerously mentally ill offenders who may also be developmentally disabled and/or chemically dependent, and who will be re-entering the community.

As of December 2001, there have been 81 persons designated as DMIO’s. Of those designated, approximately 47 been released into the community. Starting at approximately three months prior to release, “wrap-around” social support services are determined and provided. These services include, but are not limited to: mental health, chemical dependency, and developmental disability services; housing; education; and medical care. A research component of the DMIO program will evaluate its long-term effectiveness in reducing criminal activity, alcohol/drug relapse, and use of inpatient hospital beds and state psychiatric hospitals.



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The use of “club drugs” represents a relatively new trend in illicit drug use in the United States, especially in larger cities. “Club Drugs” is a general term used to refer to a group of drugs that are popular at nightclubs and all-night dance parties (known as “trances” or “raves”), though it is thought they are becoming widespread in social and recreational settings as well, especially among young people. Included in this category are the hallucinogens (MDMA, LSD, PCP, Ketamine, Psilocybin), GHB and GBL, and inhalants (nitrous oxide). Methamphetamine is also popular as a club drug.¹

Raves originated in England in the 1980’s as private, underground clubs. Other areas of the world and throughout the United States now have a rave scene. Modern hip-hop dance music and techno-light shows are common features of these “rave” clubs attracting primarily young adults ages 16-25. At all-night parties in the clubs, drugs are used to improve mood, provide energy to dance throughout the night, and increase reaction to visual stimuli. The use of club drugs is seen as a way to enhance the “rave experience.”

Risks Associated with Club Drug Use

There are significant health risks associated with club drug use. For example, MDMA, a methamphetamine analog, is known to cause long-term damage to the serotonin-containing neurons in the brain². Serotonin neurons influence emotions, memory, sleep, pain, and other higher order cognitive processes. Therefore, it is possible that MDMA can cause a variety of behavioral consequences as well as memory impairment.³

Two drugs -- Rohypnol and GHB -- which are central nervous system depressants -- may be surreptitiously added to beverages without being detected, and have been associated with “date rapes”. Both agents cause sedation and mild amnesia, sometimes making it difficult to use the victim’s testimony effectively in rape prosecutions in criminal court. GHB at higher doses has been reported to cause an array of adverse effects from unconsciousness, seizures, severe respiratory depression, to coma and possible death.⁴ The variability of

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adverse effects in these two drugs is highly unpredictable and can be fatal -- sometimes even on first use.

Club drugs are usually taken in multiple drug combinations, often along with alcoholic beverages, resulting in increased toxicity. GHB or Rohypnol, when added to alcoholic beverages, can lead to significant intensification of depression and possible coma due to synergistic mechanisms between the two substances. More than 75-80% of substance abusers experiment with combinations of two to three different club drugs to further enhance hallucinogenic effects.⁵

Most club drugs enter the U.S. from Europe. However, many of these drugs are produced domestically by “kitchen chemists” using common household chemicals.⁶ Home recipes are readily accessible on Internet sites. Unknown pharmacological agents and other contaminants pose significant risk factors and make it difficult to determine toxicity. Thus, club drugs may consist of dangerous combinations of ingredients. Not only does this lead to a greater risk of adverse effects and potential for overdose, but also lack of knowledge regarding which drug was ingested can complicate rescue efforts. Nationally, MDMA-related emergency room incidents alone increased from 253 in 1994 to 4,511 in 2000, representing an 18-fold increase.

Club Drugs in Washington State

It is difficult to measure the prevalence of club drug use. The time period during which the drug can be identified through drug screening is very short, making it difficult to detect them through standard drug testing protocols. Most of these drugs are lacking in color, odor, and taste, and are used in combination with each other or with other drugs. Traditional emergency department indicators, treatment admissions, and identifiable emergency calls to police and poison center calls related to these drugs are extremely low. Club drugs appear in relatively few instances of drug-related deaths, and are usually incidental to the primary cause of death.

However, reports of club drug use associated with acute episodes now show up on a regular basis in Washington State,



especially in Seattle. Since 1990, there has been an increase in the number of sexual assaults, overdoses, and death-related incidences associated with club drugs.^{7, 8} MDMA, GHB, Rohypnol, and Ketamine are among the synthetic drugs currently seen in Seattle.⁹ In 2000, seven deaths were recorded by the King County Medical Examiner involving MDMA, with the majority involving other drugs as well.¹⁰

The challenges of dealing with club drugs are daunting. Law enforcement officials report frustration related to club drugs because teens perceive these drugs as harmless.¹¹ Compared to other addictive but expensive drugs, such as cocaine, the low monetary costs associated with club drugs may lead young adults into thinking they have found a risk-free substance. Researchers continue to study club drugs in order to develop treatment and prevention protocols. However, the risks associated with drug experimentation often lead to unpredictable and unknown results. It will require renewed partnerships among law enforcement, substance abuse prevention and treatment professionals, educators, and public and private agencies to counter these new threats to youth and our communities.

OxyContin

According to reports from the federal Center for Substance Abuse Treatment, abuse of the semi-synthetic opioid OxyContin is increasing rapidly. OxyContin is a prescription, time-release medication designed to be taken orally, and used in the treatment of pain related to cancer and other debilitating conditions. OxyContin's major benefit is that generally it only has to be taken twice a day, and because its time-release formulation, many patients suffer fewer side effects from its use relative to other analgesic narcotic medications.

¹ Information on each of these substances, their trade and street names, and their effects are to be found at the front of this Report.

² McDowell, D. (1999). MDMA, Ketamine, GHB and the "Club Drug" scene [treatment]. In: Galanter, M., & Kleber, H (eds.) Textbook of substance abuse treatment, second edition, pp. 295-305. Washington, DC: American Psychiatric Press, Inc.

³ National Institute on Drug Abuse. (2000). www.nida.nih.gov

⁴ King 5 News. State moves to make "date rape" drug illegal. August 21, 2000.

⁵ McDowell, D. (1999). MDMA, ketamine, GHB and the "Club Drug" scene [treatment]. In: Galanter, M., & Kleber, H (eds.) Textbook of substance abuse treatment, second edition, pp. 295-305. Washington, DC: American Psychiatric Press, Inc.

⁶ National Institute on Drug Abuse. (2000). NIDA conference highlights scientific findings on MDMA/Ecstasy. *NIDA Notes* 16(5) (December 2001), 1.

⁷ De Young, K. Ecstasy influx is an enforcement problem. *The Washington Post*: August 2, 2000.

⁸ Bartley, N. Overdoses of 'gray-market' drug GHB on the rise. *Seattle Times*- south bureau. November 27, 2000.

⁹ United States Department of Justice, Drug Enforcement Administration

¹⁰ Community Epidemiology Work Group. (June 2001) Recent drug abuse trends in the Seattle-King County area, 9. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse.

¹¹ Bartley, N. Overdoses of 'gray-market' drug GHB on the rise. *Seattle Times* - south bureau. November 27, 2000.

Office of Applied Studies. (2001). Year-end 2000 emergency room department data form the Drug Abuse Warning Network. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Most people who take OxyContin as prescribed do not become addicted. However, abusers often crush the tablet and either snort it or dilute it in water and inject it. Crushing or diluting OxyContin disarms the time-release action and causes a powerful euphoria, similar to heroin. This has made the drug popular to the heroin-abusing population, and those who become addicted to OxyContin may begin to use heroin when Oxycontin is unavailable. Because of its time-release formulation, OxyContin contains 2-30 times the amount of the active ingredient *oxycodone* than is found in other pain-killers such as Percodan and Tylox.

OxyContin in Washington State

Washington State has not been immune to the upsurge in OxyContin abuse. Emergency Department mentions of OxyContin rose from 57 in State Fiscal Year (SFY) 1999, to 124 in SFY 2000, representing a 118% increase. There have also been significant increases in chemical dependency treatment admissions for non-heroin, non-methadone opiates and opioid synthetics, from 319 in SFY 1999, to 502 in SFY 2001, representing a 57% increase. Most of this growth can likely be attributed to the abuse of OxyContin.

The Department of Social and Health Services, Medical Assistance Administration, through its Therapeutic Consultation Service (TCS), is currently tracking the use of all brand name drugs, including OxyContin, among clients receiving Medicaid drug benefits. TCS is designed to better manage drug utilization, safeguard client safety, identify clients who access multiple providers for the same prescription, and help control rising health care costs related to pharmaceutical use.

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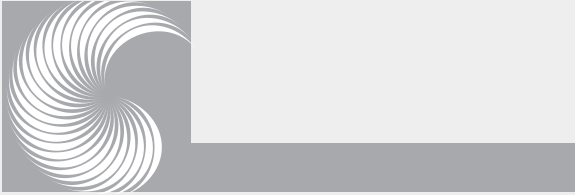
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Criminal Justice

During the last two decades, both the U.S. and Washington State have experienced a huge increase in the number of drug offense cases, coupled with increasingly harsh state and federal penalties for drug possession and distribution. This has contributed significantly to the taxing of already overcrowded courts, jails, and prisons. In addition, there were substantial increases in the number of drug-abusing offenders serving time for other crimes.

Since the implementation of the Sentencing Reform Act in Washington in 1984, the Legislature has made sentencing changes during virtually every session. One of the impacts of these changes has been a doubling of the prison population over the last decade. The number of drug offenders in prison increased 250% since 1989, rising from 912 offenders to 3,174.¹ Of the 15,306 adult prisoners in state prisons in FY 2001, 20.7% were drug offenders.² Drug offenders are not the only prisoners who need treatment. The Department of Corrections estimates that 60-80% of prisoners are in need of chemical dependency treatment, but only about 18% of prisoners received treatment in FY 2001.³ Without appropriate treatment, offenders are more likely to re-offend and return to prison. The costs of incarceration, and the costs of servicing the debt associated with the capital expansion needed to create beds for these offenders has gone from \$19 million per year in 1989 to \$89 million per year in 2001. The estimated State General Fund impact from the increased drug offender population from 1990-2001 has been over \$653 million for operating budget impact, and over \$181 million for the capital budget.

It has become increasingly clear to criminal justice personnel and policymakers that the traditional means of adjudicating and punishing non-violent drug-abusing offenders, while expensive, has not worked effectively. It has not resulted either in reducing criminal recidivism, curtailing drug use, or enhancing public safety.

Drug Offender Sentencing Reform

As the costs of incarcerating drug offenders have risen, there has been a growing awareness of the effectiveness of drug treatment in reducing re-offense and saving money. A 2002 study of publicly funded treatment examined arrest records before and after treatment indicated:

- A 21% decline in the number of clients arrested following treatment;
- A 33% decline in the number of arrests for felony offenses following treatment;
- Reduced risk of felony arrests for clients that complete treatment and for those with longer stays.⁴

A review of all drug treatment evaluation studies in the United States undertaken by the Washington Institute for Public Policy concluded drug treatment programs save substantially more than they cost. Drug courts, in particular, save almost three dollars for every dollar of taxpayer costs when victim costs are factored in. Felony recidivism rates are reduced from 43.2% without drug courts, to 39.5%, representing a decrease of about 8%.⁵ Providing treatment to drug offenders benefits the offenders, the criminal justice system, taxpayers, and communities.

With bipartisan support, 2SHB 2338 – The Drug Offender Sentencing Reform Act -- was passed in the 2002 Legislative Session. Key provisions of the bill include:

- Establishing a Criminal Justice Treatment Account (CJTA) funded out of savings to the Department of Corrections by reducing sentences for certain drug offenders;
- Utilizing savings for treatment and limited treatment support services;



- Establishing workgroups to develop:
 - A methodology for calculating the savings;
 - Formulas and grant processes for distribution of funds to counties; and,
 - County plans for submission to the formula and grant panels.
- Establishing a new drug sentencing grid and a review committee.
- Setting minimum standards for the participation of offenders in drug courts;
- Authorizing studies of the effectiveness of the new sentencing grid and drug courts.

In State Fiscal Year 2005, the amount available for treatment and support services is currently estimated to be \$8.25 and will serve more than 2,000 individuals in community-based treatment, as well as drug-addicted offenders in prisons.

Drug Courts

The basic strategy behind drug courts is to use the power of the criminal justice system to force offenders who are addicted to illicit drugs and/or alcohol to undergo substance abuse treatment. By treating the disease of addiction, criminal recidivism and the social and economic costs associated with drug use, as well as crime and corrections costs, can be reduced.

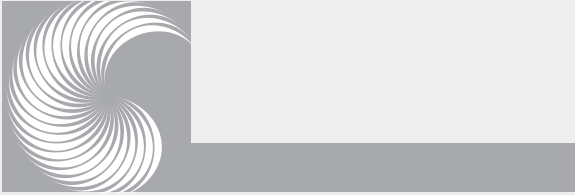
The first drug courts started operating in Washington State in 1994. Adult drug courts currently operate in 12 counties: Clallam, Clark, Cowlitz, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, and Yakima. A thirteenth drug court is in the planning stages for Mason County. There are also four youth drug courts and three tribal courts.

Drug courts will be a primary mechanism of providing supervised treatment under 2SHB 2338. The legislation also calls for an evaluation of the cost-effectiveness of existing drug courts and their impacts on reducing recidivism by March 1, 2003.

Chemical Dependency Disposition Alternative (CDDA)

The CDDA program provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. Enabling legislation was enacted in 1998. The program represents a collaboration between the Juvenile Rehabilitation Administration, Medical Assistance Administration, DASA, local juvenile courts, University of Washington, and county alcohol/drug coordinators. Annual reports are provided to the Legislature on the effectiveness of CDDA programs. During State Fiscal Year 2001, 537 youth received treatment through CDDA.

ESSB 6535, passed during the 2002 Legislative Session is intended to increase the numbers of youth eligible for CDDA. It would do so by permitting the courts to adjust the crime level of the charges upward, and then suspend the sentence so that a juvenile offender can be ordered to complete a full course of treatment under CDDA.



New Initiatives

There are several new initiatives underway to deal with the complex needs of juveniles who have come into contact with the criminal justice system. A new program in Seattle-King County – Reclaiming Futures – seeks to work toward long-term, countywide system reforms. The goals of Reclaiming Futures are to:

- Design and implement an effective continuum of assessment, treatment, and supports for every child with a substance abuse problem adjudicated through local courts;
- Provide supports for substance-abusing youth and youth with co-occurring disorders beyond their court and treatment system participation; and

- Redirect and invest both current and future funding for these youth based upon their needs, the success of the model, and the will of the community.

Reclaiming Futures is targeting 100 youth offenders who are substance abusers and/or dually diagnosed and their families per year. A comprehensive blended justice and treatment approach will ensure linkages and coordination of services which are culturally competent and directed at the unique needs of each youth and family. A full-scale evaluation is planning with the assistance of the Robert Wood Johnson Foundation.

¹ From a March 12, 2002 Presentation by Washington State Senate Committee Services Staff.

² Adult Corrections Caseload Forecast. Caseload Forecast Council. November 2001.

³ DOC CD Program Overview March 2001

⁴ DSHS Research & Data Analysis Division Fact Sheet 4.42. March 2002

⁵ Washington State Institute for Public Policy. (May 2001). The comparative costs and benefits of programs to reduce crime, 23-26. Olympia, WA.

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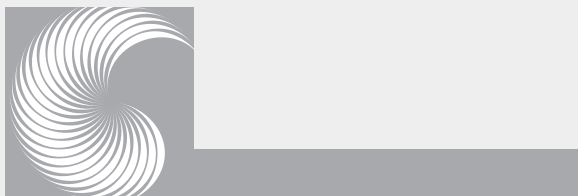
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DRUG-AFFECTED INFANTS AND CHILDREN

Over the years, the Division of Alcohol and Substance Abuse has striven to educate key stakeholders regarding the nature of addiction and the recovery process, and promote understanding of alcohol and drug use by pregnant and parenting women as a public health issue. Substance abuse during pregnancy is a serious problem, as it puts both mother and child at risk. A 1997 report by the Department of Social and Health Services (DSHS), Research and Data Analysis (RDA), estimates that 8,000-10,000 infants each year are born to women in Washington who use alcohol or other drugs during pregnancy. Approximately 800-1,000 infants are born with measurable effects that can be attributed to substance abuse during pregnancy.¹ Other effects may manifest themselves later in a child's development.

Substance abuse is also a significant contributing factor to the incidence of child abuse and neglect. DSHS' Office of Children's Administration Research found substance abuse was involved in 49% of reported child abuse incidents.² Due to the insufficient number of homes in which to place these children, chemical dependency treatment services and child protection service agencies are seeking strategic ways to more effectively engage abusive parents in treatment. Substance abuse treatment is necessary to improve the health and welfare of children and maintain family units. Many of these families are impoverished and experience complex problems, increasing the challenge for service providers. Placing chemical dependency counselors in local Child Protective Services' offices to provide outreach services, and developing sites where families can receive several services under one roof are two innovative responses to this crisis.

As required under HB 3103 enacted in 1998, the Department of Health (DOH) has developed "Guidelines for Screening for Substance Abuse During Pregnancy" (June 1999). DOH continues to train physicians throughout Washington State to assist them in identifying pregnant and lactating women at risk of producing a drug-affected baby.

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) Services

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are the leading known causes of mental retardation, and are entirely preventable. FAS/FAE are both national and state problems that impact children, families, and communities. In 1995, the Washington State Legislature unanimously adopted legislation directing DSHS, Office of the Superintendent of Public Instruction, DOH, and Department of Corrections to execute an agreement to ensure the coordination of programs serving children who have FAS/FAE, and women at high risk for having children with FAS/FAE. The legislation also provided for family advocacy groups to participate in the planning, development, delivery, and review of services available to FAS/FAE children and families.

Since 1995, the Division of Alcohol and Substance Abuse (DASA) has voluntarily served as program chair of the Fetal Alcohol Syndrome Interagency Work Group to ensure continued development and implementation of services targeted at identification, prevention, and intervention with individuals and families suffering from FAS/FAE. The FAS Family Resource Institute is a grassroots non-profit organization of parents working together with professionals to identify, understand, and care for individuals and families affected with FAS/FAE. The FAS Diagnostic and Prevention Network consist of seven clinical sites statewide under the auspices of the University of Washington, providing a broad range of screening, diagnostic, education, training, and referral services.

Parent-Child Assistance Program (P-CAP)

A prime opportunity to intervene with substance-abusing women is during pregnancy. Early intervention during the prenatal period increases the likelihood a woman will successfully recover from her substance abuse and that babies

will be born drug-free and with health uncompromised by the mother's alcohol or drug abuse.³

DASA's Parent-Child Assistance Program (P-CAP) provides referral, support, and advocacy services to approximately 360 high-risk substance abusing pregnant and parenting women and their young children annual in King, Pierce, Spokane, Grant, and Yakima Counties. Services include referral for substance abuse treatment and continuing care, assistance in accessing local resources for family planning, safe housing, health care, domestic violence service, parenting skills training, child welfare, child care, transportation, and legal services. Advocates work with clients to ensure necessary services are delivered in a timely manner. Collaborative relationships include liaison with courts, schools, vocational centers, therapeutic childcare centers, and the statewide Fetal Alcohol Syndrome Diagnostic and Prevention Network established by the University of Washington.

Such programs include assertive outreach to engage and treat women prior to the development of problems such as loss of child custody, and case management to coordinate the delivery of wrap-around services. Additional challenges include coordinating treatment with prenatal and other medical appointments, providing childcare for infants and older children, and offering parenting support and training.

Comprehensive Program Evaluation Project (CPEP) - Safe Babies, Safe Moms

Comprehensive programs addressing multiple treatment needs have demonstrated effectiveness in working with families and children affected by substance abuse. DASA has formed a state-level consortium with Research and Data Analysis, Economic Services Administration, Medical Assistance Administration, and Children's Administration within DSHS, and DOH to respond to the disturbing number of births of alcohol- and drug-affected infants. Three pilot program

sites, in Snohomish, Benton-Franklin, and Whatcom Counties, have been established to work with 250 high-risk substance-abusing pregnant and parenting women and their children. A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site. TICM provides assertive outreach and engagement, linkages to necessary services including chemical dependency and mental health treatment, family planning, parent education and support, therapeutic childcare, and early childhood intervention and development services. A continuum of chemical dependency services is provided with an emphasis on enhanced long-term residential treatment, up to 18 months of transitional housing, and other safe and alcohol/drug-free housing options. Length of involvement in both residential and outpatient chemical dependency treatment has been shown to be associated with better birth outcomes.⁴ CPEP's goal is to stabilize women and their young children, identify and provide necessary interventions, and assist women in gaining self-confidence as they transition from public assistance to self-sufficiency.

A two-part evaluation will be undertaken. The first, completed in 2001, focused on program development and implementation issues. The second, due at the end of 2003, will evaluate mother- and child-based outcomes. The lessons that the state implementation team is learning from implementing these pilot projects are many. The findings of the first evaluation discovered that the team approach to serving clients takes a lot of work, but is a unique and essential aspect of the CPEP program. Participation in a program that requires providers to work together as they serve clients improves the working relationships among those providers. At the state and local levels, staffs are learning about the importance of using a team approach to serve clients, as well as the challenges that accompany such an approach. The teams are also learning more about the availability of essential community resources required to meet the needs of the CPEP clients. Finally, the state team is learning how to prioritize the





resources available to serve the CPEP clients and to identify some efficiencies in program operations.

Future Challenges

The efficacy of program such as P-CAP and CPEP can only be measured over the long-term, as the effects of maternal alcohol and substance abuse are spread over the lifetimes of

drug-affected infants and children. In addition, comprehensive evaluations are necessary to determine the optimal mix of services to be offered to maximize impact and achieve positive outcomes. Commitments are needed to ensure continuation of programs, provide for evaluation, and to expand their reach.

¹ Cawthon, L. (1997). Substance abuse during pregnancy: prevalence, effects, and costs. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis.

² Data from Office of Children's Administration Research (OCAR). (1999). Olympia, WA: Washington State Department of Social and Health Services.

³ Center for Substance Abuse Treatment (1993). Pregnant, Substance-Using Women (Treatment Improvement Protocol (TIP) Series #2). Washington, DC: U.S. Department of Health and Human Services.

⁴ Watts, D., & Krohn, M. (1994). Preliminary findings from the MOMS Project. Seattle, WA: University of Washington.

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METHAMPHETAMINE

Washington State is experiencing a methamphetamine epidemic. The number of methamphetamine laboratories reported to the Department of Ecology (Ecology) rose from 38 in 1990 to 1,886 in 2001, a more than 50-fold increase.¹ Although admissions for methamphetamine are still lower than those for either alcohol and marijuana, publicly funded treatment admissions for methamphetamine more than doubled from 214 to 538 for youth, and 1,853 to 4,308 for adults from 1997 to 2001.

The impact upon public health and safety from this epidemic can be devastating. Methamphetamine use is linked to the transmission of sexually transmitted and blood-borne infections, including syphilis, HIV, and hepatitis C, through sharing of injection drug-using equipment and unprotected sexual activity. Data from King County indicates that 47% of men who have sex with men and inject methamphetamine are infected with HIV.²

Research indicates the effects of methamphetamine use are both short- and long-term. Addiction often involves repeated and prolonged use for as long as several weeks. During this period, the user may experience feelings of aggression, tendency toward violence, anxiety, paranoia, and hallucinations. Individuals may exhibit signs of toxic psychosis, becoming belligerent and dangerous at the same time. The risk of child abuse and domestic violence is significantly increased. Prolonged exposure to relatively low levels of methamphetamine can result in long-lasting functional and molecular changes in the brain.³

Methamphetamine use is linked to crime. The Arrestee Drug Abuse Monitoring Program (ADAM) in Spokane County found that in 2000, 21% of males and 33.3% of females arrested tested positive for methamphetamine.⁴

Methamphetamine laboratories are found in all areas of Washington State. More than 31% (585) of the labs reported in

2001 were in Pierce County. But they are now spreading. In Benton County, 85 labs were discovered in 2001, 41 in Grays Harbor County, and 57 in Clark County. The number of labs reported in Spokane County in 2001 (248) is more than 22 times the number in 1998 (11). Statewide, the numbers of new labs reported to Ecology seem to have leveled off during the last 10 months.⁵ Guarding suspected sites before and after assistance from the Washington State Patrol's Incident Response Team and its mobile lab stretches the limited policing resources of smaller jurisdictions. Four local law enforcement agencies – King County Sheriff's Office, Seattle Police Department, Pierce County Sheriff's Department, and the Tacoma Police Department – have their own methamphetamine incident response teams.

Newer methods of synthesizing methamphetamine have made it possible to produce larger quantities of a more potent drug in less time. Although active labs are typically located at rental properties, there is an increase in the numbers found in motels, state campgrounds and federal forests. In the five-year period between 1995-2000, the Washington State Department of Health received notification of 16 methamphetamine laboratories in motels. In 2001 alone, 16 labs in motels were reported. Chemical residues left behind can cause chemical burns, upper respiratory distress, and, in some instances, death. Chemical contamination resulting from methamphetamine production has been found at lab sites up to two years after they were closed down.⁶

Residential methamphetamine lab cleanup crews estimate children are or have been present at 35% of the drug labs they are called to investigate.⁷ It is now routine for law enforcement professionals to call in Child Protective Services to intervene on behalf of these children, who are usually removed from the home until methamphetamine-addicted parents have stabilized and are no longer using drugs.



Turning the Tide

Given its current virulence and growth, turning the tide on the methamphetamine epidemic requires significant, new and expanded cross-system collaborations at both the state and community levels. Efforts will need to focus on:

- Development and implementation of community-based prevention strategies;
- Expanded law enforcement efforts, including adequate, proactive investigative capacity at the local and regional level;
- Enhanced cleanup capabilities;
- Planning for increased involvement of child welfare, child protection, and other social service agencies;
- Expanded chemical dependency treatment capacity, both for those involved in methamphetamine labs who are not sentenced to jail or prison, and for addicted offenders following their release from prison.

The Governor's Methamphetamine Coordinating Council has played an important role in ensuring cross-system collaboration, reaching across law enforcement, public health, prevention, and treatment fields.

The methamphetamine epidemic presents new challenges for targeted prevention activities. The information on child abuse and neglect specific to parents and caregivers who are abusing or are addicted to methamphetamine is limited and anecdotal. What is known, however, is that most studies report that between one-third and two-thirds of substantiated child abuse and neglect reports involve substance abuse including alcohol and other drugs.⁸

Treatment works. Health care costs declined, and employment and earnings increased following treatment. A 2000 study of adults who received inpatient chemical dependency treatment demonstrated a 91% drop in days involving amphetamine (including methamphetamine) use in the 30 days prior to the six-month follow-up.⁹

But resources are inadequate to meet current needs for treatment, no less those that can be projected in the course of the epidemic. Currently, it is estimated that 70% of offenders in prison are substance abusers, and it is likely that an increasing proportion of these will be methamphetamine addicts. Of those offenders who receive prison-based treatment, only 20% continue to receive treatment in the community after they are released. According to the Department of Corrections (DOC), there are 205 inmates released each month who have received prison-based treatment, but for whom DOC has no resources to assure continuing community-based treatment.



Without such treatment upon release, it is likely that many offenders will relapse and re-offend, adding still further to the methamphetamine problem.

In Washington State 6,223 adults and youth with primary amphetamine/methamphetamine addiction were admitted to publicly funded treatment in State Fiscal Year 2001, but DASA-funded treatment currently is only available to a small percentage of those who need it. Without treatment, those who are not imprisoned as a result of methamphetamine involvement may simply continue their involvement at new locations and impact still more communities. Heightened

risks for child abuse, domestic violence, and the transmission of blood-infections will remain. Without treatment, family reunification efforts will be impossible, with resulting higher social welfare costs.

The methamphetamine epidemic can be stemmed, but it will necessitate the development of new partnerships, collaboration, and increased commitment from policymakers to address the epidemic's complexities. A multi-faceted approach holds out the promise of improving the health, safety, and welfare of Washington communities.

¹ Department of Ecology, November 3, 2000.

² Office of the Superintendent of Public Instruction. (1999). Washington State survey of adolescent health behaviors, 1998. Olympia, WA.

³ Seattle/King County Department of Public Health. (1999). HIV/AIDS in men who have sex with men (MSM), and MSM injection drug users (MSM/IDU), Fact Sheet. Seattle, WA.

⁴ National Institute on Drug Abuse. (1998). Methamphetamine abuse and addiction. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health.

⁵ Office of Justice Programs. (2000). Arrestee Drug Abuse Monitoring Program 1999 annual report, 82-83. Washington, DC: U.S. Department of Justice. National Institute of Justice.

⁶ Office of Toxic Substances, Washington State Department of Health. (2000). Annual residential drug lab costs, 1999. Olympia, WA.

⁷ Governor's Council on Substance Abuse. (2000). Methamphetamine abuse in Washington State, p. 15. Olympia, WA: Washington State Department of Community, Trade and Economic Development.

⁸ United States General Accounting Office. (1997). Parental substance abuse: implications for children, the child welfare system, and foster care outcomes. Statement of Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division, before the Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, October 28, 1997.

⁹ Baxter, B., & Stevenson, J. (1998). Changes in clients' alcohol/other drug use and lifestyles during publicly supported chemical dependency treatment in Washington State: October 1996 – September 1997 discharges. Seattle, WA: University of Washington Alcohol and Drug Abuse Institute.

¹⁰ McKay, J., Donovan, D., McLellan, T., Krupski, A., Hansten, M., Geary, K., Cecere, J. (2000). Evaluation of full vs. partial continuum of care in the treatment of publicly funded substance abusers: Washington State TOPPS I Project final report. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse.

¹¹ Governor's Council on Substance Abuse. (2000). Methamphetamine abuse in Washington State, p. 25. Olympia, WA: Washington State Department of Community, Trade and Economic Development.

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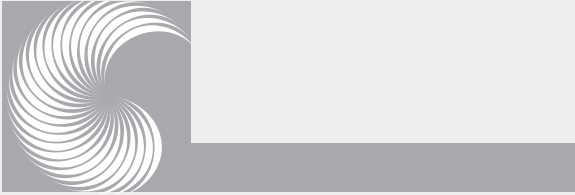
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OPIATE SUBSTITUTION TREATMENT

The Office of National Drug Control Policy estimates there may be as many as 980,000 users of heroin nationwide.¹ It is estimated that approximately 29,000 Washington State residents have been dependent upon opiates (primarily heroin) during their lifetimes.² Most do not receive treatment. The National Institutes of Health estimate the financial costs of untreated heroin addiction to individuals, families, and society in the U.S. at approximately \$20 billion each year.³

Chronic heroin addicts pose a significant public health risk to our communities. As a large majority are injection drug users (IDUs), heroin addicts are more likely to contract and spread HIV and hepatitis B and C. The federal Centers for Disease Control and Prevention estimate that IDUs (most of whom are heroin users), their sexual partners, and their offspring account for approximately 35% of new HIV infections each year.⁴ Chronic heroin users are more likely to engage in criminal activity, and are more likely to place increased strain upon public resources in welfare costs, emergency room and hospital admissions, and psychiatric hospitalization. The rate of heroin-related deaths in King County grew more than 170% from 1990 to 1998, and the County now ranks third in the nation for both heroin use and overdoses. In 1998, there were more unintentional opiate overdose deaths in King County (140) than traffic fatalities (119).⁵

It should be noted, however, that heroin-related deaths in King County have declined approximately 30% since 1998, to 99 in 2000. Emergency room mentions of heroin/morphine have similarly declined. This is at least partially due to public health measures adopted by city and county government to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. The number of chemical dependency treatment admissions for heroin increased from 1,140 in 1998 to 2,101 in 2000.

Scientifically Proven

Methadone and other forms of opiate substitution have been shown scientifically to work effectively in the treatment of heroin addiction. In its 2000 National Drug Control Strategy, the White House Office of National Drug Control Policy called methadone therapy “one of the longest established, most thoroughly evaluated forms of drug treatment.”⁶ A Consensus Panel convened by the National Institutes of Health (NIH) in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.” The 12-member panel strongly recommended broader access to methadone maintenance treatment programs for people addicted to opiates, and that federal and state regulations and other barriers impeding this access be eliminated. A 1998 review by the General Accounting Office found that methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law abiding, productive citizens.⁷

Opiate substitution treatment clinics have been operating in Washington State for more than 25 years. As of December 2001, there are 11 opiate substitution treatment clinics operating in four counties in Washington State. Six fixed locations and one mobile clinic are in King County, two of which serve only private-pay patients. In addition, there is a pilot program at Harborview Medical Center through which physicians provide opiate substitution treatment to clinically stable patients. Pierce County has two clinics, and Spokane and Yakima Counties each have one. Clark County contracts with an opiate substitution treatment program in Portland, Oregon to serve its residents. As of January 1, 2001, 2,951 individuals were receiving opiate substitution treatment for heroin addiction. Of these, 1,865 (63.2%) were publicly funded. There are waiting lists, sometimes longer than six months, for the publicly funded slots at each of the operating



clinics, postponing treatment at that critical juncture when addicted individuals are prepared to access it. In addition, people with chronic heroin addiction living in rural and even some urban areas have to travel six days a week to King, Pierce, Yakima, or Spokane Counties or to Portland to access treatment. In King County, it is estimated that there are between 15,000-20,000 injection drug users, 70% of whom are chronic heroin users and could benefit from treatment.

In SFY 2001, 4,776 individuals in Washington State received opiate substitution treatment; 2,870 of these patients received treatment funded through the Division of Alcohol and Substance Abuse (DASA), at a cost of \$4.78 million.

Evaluating Cost-Effectiveness and Efficacy

SSB 5417 [now RCW 7096A.420(4)] requires DASA to provide an “outcome analysis” of programs providing opiate substitution treatment. In fact, DASA has been studying opiate substitution treatment for several years and has established appropriate performance measures for evaluating cost effectiveness and efficacy. In doing so, it has contracted with the University of Washington Alcohol and Drug Abuse Institute to undertake a management study to answer two questions:

- Does opiate substitution treatment contribute to reducing the negative consequences of opiate addiction – crime, health problems, and reliance on welfare?
- Does opiate substitution treatment support the Department of Social and Health Services’ mission to assist clients in maintaining safe, secure, self-sufficient, and healthy lives?

The results of the 2001 study are compelling. In a sample of 726 publicly funded clients discharged from treatment, the following outcomes were achieved:

- Property crimes were reduced by 56%;
- Emergency room visits decreased by 58%;
- Overall arrest rates declined by 43%;
- Drug offense arrests dropped by 52%;
- Medical hospital admissions were reduced by 55%;
- Utilization of major health care services were lowered by 46%;
- Psychiatric hospitalization declined by 25%.

Rates of change for those in treatment for more than a year were even greater. Especially striking was reduction in crime for those involved in treatment for one year or more. The percentage of patients arrested (both publicly funded and private-pay) declined from 30% in the year prior to treatment to 10% during treatment prior to discharge, a 67% reduction. (Average length of treatment for those in treatment longer than one year was 956 days – almost three years – for publicly funded patients, and 979 days for private-pay patients.) Arrest rates are likely even lower among patients who remain in treatment over the longer term. Typical clients were white, almost 40 years old, and were parents with children. Treatment has been shown to have a stabilizing effect on clients, and helpful in moving clients off of welfare and toward self-sufficiency.⁸

Treatment Works

At admission for opiate substitution treatment, 86% of publicly funded clients used heroin at least daily. By discharge, only 19% were daily users, representing a decline of 78%. Required urine samples from all opiate substitution patients taken in 2000 were analyzed by Comprehensive Toxicology Services to see whether there were reductions in illicit drug



use. Of 19,711 urine specimens that tested positive for methadone, only 1,929 (9.8%) were positive for other drugs. It should be noted that patients are required to provide more specimens in the early stages of the program, when they are less likely to be stabilized and drug-free. While it is often true that opiate substitution treatment does not result in total abstinence from opiates by all clients, it clearly facilitates substantial reductions in the frequency and likelihood of heroin use.

Challenges Ahead

In recognition of the success of opiate substitution treatment in improving public health and safety, in 2001 the Washington State Legislature passed Substitute Senate Bill 5417. Under the new statute, county legislative authorities can no longer prohibit opiate substitution treatment programs in their jurisdiction. Instead, upon receiving an application for certification of an opiate substitution treatment program, DASA is required to consult with county and city legislative authorities, demonstrate a need in the community for such a program, and certify only as many program slots as can be justified by the need. Two public hearings must be held, and programs must be sited in accordance with appropriate county or city land use ordinances. Counties now have the authority to lift the lid of 350 participants per program. Plans are moving ahead in Thurston County to open a new opiate substitution treatment program. In addition, preliminary interest in opening new programs has been expressed in Clark, Cowlitz, and Snohomish Counties.

The NIH Consensus Panel laid out four challenges for the future of opiate substitution programs:

- Making treatment as cost-effective as possible while maintaining or improving quality of care.
- Increasing the availability and variety of treatment services.

- Including and ensuring wide participation by physicians trained in substance abuse to oversee medical care.
- Providing additional funding for opiate addiction treatment and coordinating these services with other necessary social services and medical care.

The Panel also recommended that opiate-dependent individuals under legal supervision – probation, parole, in jails and prisons – should have access to methadone treatment, and called on the White House Office of National Drug Control Policy and the U.S. Department of Justice to take the necessary steps to implement this recommendation. Finally, the Panel noted that stigmas about addiction and methadone are barriers to expanding treatment, and that leadership from policymakers and the medical community are needed to educate the public.

New Developments

Several recently adopted and proposed regulatory and legislative developments in both regulation of opiate substitution treatment programs and in the use of new medications will impact our ability to meet these challenges. These will require attention from DASA, the medical community, and local providers to ensure more clients can gain access to cost-effective, quality services.

New federal regulations transfer regulatory authority for opiate substitution treatment programs from the U.S. Food and Drug Administration (FDA) to the Center for Substance Abuse Treatment (CSAT). Federally approved accreditation bodies such as the Rehabilitation Accreditation Commission (CARF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will now conduct program audits in lieu of federal auditors. In 2001, DASA applied for and was approved as an opiate substitution treatment program accreditation body, the only state alcohol and drug abuse agency in the United States to receive such recognition.



As part of a federal experiment, several states have implemented physician-based opiate substitution treatment programs on a limited basis, and draft federal guidelines have been distributed for review. Federal and state statutes and regulations will need to be revised and implemented before the programs can be fully established. Such programs may be most appropriate for stable, long-term patients who no longer require extensive monitoring and intensive counseling services. The transfer of long-term, stable patients to physician-based programs would, in turn, free up badly needed resources and treatment slots in opiate substitution clinics.

Such a program is currently being piloted between Evergreen Treatment Services (ETS) and Harborview Medical Center, and shows great sign of promise. Beginning in January 2000, 30 patients who were clinically stable for at least one year were transferred to Harborview (10 in January, and the rest during the summer of 2000). They had each been receiving

opiate substitution treatment for between two and 22 years, with a mean of ten years. Of these patients, 27 currently remain in the program after a year or more; one transferred to an opiate substitution treatment program in another state; one transferred back to the ETS mobile van program; and one died (cause of death was unrelated to drug use.) None was discharged from treatment because of rule violations related to drug use.

A final challenge is finding ways to reduce demand for methadone maintenance treatment by intervening in the lives of patients before such treatment is needed. Opiate substitution treatment is for patients whose addiction has already become chronic. Earlier intervention with a full range of treatment and the use of newer and promising medications such as naltrexone and buprenorphine may prevent the need for opiate substitution and contribute to ensuring healthier individuals and healthier communities.

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² Kohlenberg, E., Yette, R., and Mack, C. (1992) Needs assessment data project report: Division of Alcohol and Substance Abuse, Fiscal Year 1990. Olympia, WA: Department of Social and Health Service, Office of Research and Data Analysis.

³ National Institutes of Health. (1997) Effective medical treatment of heroin addiction: NIH consensus statement 1997. November 17-19, 1997.

⁴ Centers for Disease Control and Prevention. (1998). HIV/AIDS surveillance report. Atlanta, GA: U.S. Department of Social and Health Services, Public Health Service.

⁵ Solet, D., Hagan, H., Nakagawara, J., Plough, A., and Ball, J. (2000). Unintentional Opiate Overdose Deaths – King County, 1990-1999, *Morbidity and Mortality Weekly*, 49(28), 636-640.

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⁶ Office of National Drug Control Policy. (2000). National drug control strategy: 2000 annual report, 57. Washington, DC: Office of the White House.

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⁸ Baxter, B., and Albert, D. (2002). Management Report – Determining the value of opiate substitution treatment. Olympia, WA: Washington State Division of Alcohol and Substance Abuse. Ibid.

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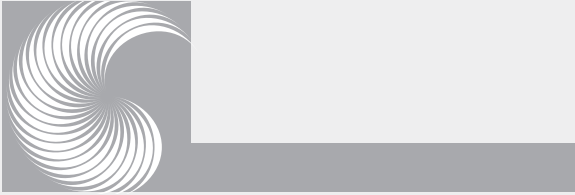
Methamphetamine

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From Research
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There is a growing movement, both nationally and within Washington State, to integrate substance abuse research, policy, and clinical practice. A significant impetus for this movement came from a 1998 Institute of Medicine report entitled *Bridging the Gap Between Practice and Research. Forging Partnerships with Community-Based Drug and Alcohol Treatment*¹. This report documented the growing isolation between clinical-provider and research communities. Its authors argued that this widening gap between research and clinical practice is one of the major threats to the survival of the chemical dependency treatment system. It made a number of recommendations directed at facilitating partnerships between practice, research, and policy.

Statewide Bridging the Gaps Workgroup

In response to the Institute of Medicine report, the Division of Alcohol and Substance Abuse (DASA) formed a statewide Bridging the Gaps Workgroup in 1999 to begin the work of forging partnerships with treatment providers, providers of prevention services, researchers, and policymakers within Washington State. This workgroup currently includes about 50 members. Membership on the Statewide Bridging the Gaps Workgroup is open to interested persons who represent the research, practice, policy, or client advocacy communities.

The workgroup has had a number of achievements, including planning two statewide research conferences that blended research, practice, and policy, as well as preparing the groundwork for Washington State to become a “node” in the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN). The workgroup currently meets about three times a year and continues to provide an opportunity for exchange among researchers, providers, and policymakers on issues of mutual interest. A current goal of the workgroup is to lay the groundwork necessary for Washington State to successfully compete for a Treatment Improvement Collabora-

tive grant from the federal Center for Substance Abuse Treatment. This grant would allow significant expansion of current collaborations among the research, practice, and policy communities within Washington State.

Washington State Node of the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN)

In January, 1999, NIDA announced the formation of the Clinical Trials Network (CTN) in response to the 1998 Institute of Medicine report. The structure of the CTN is similar to clinical trial projects on AIDS, cancer, and other medical research challenges undertaken by the National Institutes of Health. The ultimate goal of CTN is to have multiple regional “nodes” around the United States, with at least 10 community treatment programs (CTP’s) affiliated with each node. Each node will participate in the development, implementation, and evaluation of behavioral and pharmacological therapies targeted at treatment as delivered in the real world settings of the affiliated CTP’s. The purpose is to take new treatments that have been shown to be effective in specialized treatment research settings with restricted patient populations, and apply these treatments on a wide-scale basis in practice settings.

The Washington State Node is one of 14 nodes currently within the national CTN. It is based at the University of Washington Alcohol and Drug Abuse Institute (ADAI), and has eight community-based treatment programs (CTP’s) as full collaborators. Washington State CTP’s include Evergreen Treatment Services, Seattle; Residence XII, Bothell; Recovery Centers of King County, Kent; Kitsap Recovery Center, Bremerton; Evergreen Manor, Everett; Providence Behavioral Health Services, Everett; Vancouver Division of Portland Veteran’s Administration Medical Center, Vancouver; Triumph Treatment Services, Yakima. Dennis Donovan,



Ph.D., serves as the Principal Investigator of the Washington State Node.

At the present time, the Washington State Node is participating in one national CTN protocol on buprenorphine as a detoxification medication for the treatment of opiate abuse and dependence. This trial is being conducted at Providence Behavioral Health Services, Everett, and is designed to deter-

mine the relative advantages of three rates (7 days versus 30 days versus 60 days) of buprenorphine-naloxone (BUP/NX) detoxification following four weeks of BUP/NX flexible dosing stabilization.

For more information about the Bridging the Gaps Workgroup or the Washington State Clinical Trials Network, contact the Research and Evaluation Section at DASA.

¹ Lamb, S., Greenlick, M., & McCarty, D. (Eds.). (1998). Bridging the gap between practice and research: forging partnerships with community-based drug and alcohol treatment. Washington, DC: National Academy Press.

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Treatment Completion and Retention

As part of its Accountability Scorecard with the Governor, the Department of Social and Health Services has pledged to ensure better outcomes for residents it serves and, in doing so, help build safer and healthier communities. As part of this commitment, the Division of Alcohol and Substance Abuse (DASA) has pledged to improve completion and retention rates for publicly funded patients receiving chemical dependency treatment.

This choice of strategic focus is soundly based in the science of treatment. Research has consistently indicated that patients who complete treatment experience more favorable outcomes than those who do not. They are more likely to remain abstinent, have lower medical care utilization, have fewer requirements for psychiatric care, are less likely to commit crimes, are more likely to become employed, and have higher post-treatment wages. Pregnant women who complete treatment are more likely to have full-term deliveries, babies with higher birth weights, and experience fewer fetal or infant deaths. These trends hold true regardless of whether patients are adolescents or adults. While admission to treatment itself has been demonstrated to deliver these same effects, treatment retention and completion further enhance improved outcomes.

To represent its commitment to improved patient outcomes and safer and healthier communities, DASA has pledged that by July 2003, 76% of adults and 62% of youth will complete residential treatment. To accomplish this goal, DAS has assembled an internal working group, with representatives from its treatment, research, certification, research, and planning and policy sections, as well as regional administrators, to spearhead this effort. DASA is also working closely with provider advisory groups to implement this objective.

With the assistance of representatives from counties, tribes, and residential and outpatient providers, DASA reviewed definitions of discharge types and incorporated them into the data dictionary of the new TARGET 2000 system. Language was then developed for use in contracts with residential providers, with the expectation that requirements will soon be extended to outpatient providers as well.

DASA is quite aware that the patient mix at every treatment facility is different, and so while it is expected that treatment retention/completion rates can improve at every agency, no across-the-board target can be reasonably applied. With this in mind, DASA Research and Evaluation Section is working with treatment program managers to understand and evaluate the usefulness of “case mix adjustment” in helping agencies set reasonable targets for treatment completion.

Training will be a key element to fulfilling DASA’s commitment. Dissemination of best practices within all treatment agencies as well as the integration of all components of treatment and aftercare will be necessary to effect positive change. The Treatment Completion Workgroup will be working with the statewide “Bridging the Gaps” Workgroup to develop a list of science-based practices that have been shown to enhance treatment completion.

Between July-November 2001, completion rates for adults (76%) and youth (62%) in residential treatment already met or exceeded statewide goals. However, it is fully expected that sustained commitment in this area will result in even better patient outcomes, and improve the health, safety, and vitality of Washington’s diverse communities.

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Workforce Development Issues For Treatment and Prevention Professionals

How does a workforce of several thousand people spread out over the geographic expanse of Washington State stay skilled in delivery of the latest research-based chemical dependency treatment? How does this workforce stay abreast of rapidly evolving best practices in prevention? Moreover, what will attract new people into a field usually considered underpaid and under-appreciated?

The Division of Alcohol and Substance Abuse (DASA) takes these issues very seriously. In cooperation with other federal and state agencies, colleges and universities, professionals in the field, and other interested parties, DASA is addressing these issues in both the treatment and prevention fields.

Chemical Dependency Treatment

Effective chemical dependency treatment requires knowledgeable and skilled treatment professionals equipped to provide quality care for their patients. Unfortunately, service provider agencies report increasing difficulties in recruiting and retaining qualified and trained chemical dependency professionals (CDPs).

One reason for the shortage of professionals may be that salaries are not keeping pace with new education and proficiency requirements. Recently expanded education requirements, without similar increases in compensation, may be causing potential entrants to the field to choose other career paths.

A counselor survey was conducted to assess the actual salaries paid within various treatment settings. The results of that survey were published in 2001 in a report title *Salaries of Chemical Dependency Counselors in Washington State: Findings from a Pilot Survey*. Salaries varied according to degree of responsibility with the highest level associated with clinical supervisors, the intermediate level with counselors, and the lowest level with interns. Median annual salary for a CDP was \$29,848.

In collaboration with interested colleges and providers, DASA has formed a Counselor Shortage Committee. Two main goals of the Committee are: 1) To determine barriers that may be affecting recruitment and retention; and, 2) To develop a strategy to increase the candidate pool of CDPs statewide. In 2002, the Committee will be examining the Washington statute defining CDP requirements and will recommendations for amendments.

The Committee has also been working more directly on recruiting and retaining CDP's. More than 25,000 copies of a new brochure entitled "Why YOU Should You Become a Chemical Dependency Counselor" have been distributed through chemical dependency providers, colleges, vocational schools, state agencies, and the Washington State Alcohol and Drug Clearinghouse.

DASA enlisted the Alcohol/Drug Help Line to design a website for chemical dependency positions around the state. Individuals can now review position announcements and submit their resumes free of charge. This website is linked with Department of Health, colleges, universities, tuition waiver information, and the current Revised Code of Washington (RCW) and Washington Administrative Codes (WAC) related to certification.

DASA continues to facilitate discussions with community colleges – a staple in providing required education classes for prospective counselors – to identify and address educational barriers. Representatives from DASA, colleges, universities, and other training institutions are developing consistency between the state's various chemical dependency education programs. This will allow students more latitude to transfer between schools, especially when required internships are not available in their geographic areas.

DASA supports and manages a tuition waiver program for low-income individuals studying to become certified chemi-

cal dependency professionals at state colleges and universities. Historically, the program has targeted ethnic minorities and persons with disabilities interested in entering the field.

DASA and the committee are also helping develop regional solutions through work with the Northwest Frontier Addiction Technology Transfer Center (NFATTC). A survey of counselors for the Pacific Northwest states of Alaska, Idaho, Oregon, and Washington conducted for NFATTC found that 71% of chemical dependency counselors hold a Bachelor of Arts degree or better, and 70% have completed specialized educational coursework in substance abuse treatment. About 87% of Washington respondents have completed specialized education compared with 60-63% for the other three states. The report, *"Substance Abuse Treatment Workforce Survey, A Regional Needs Assessment,"* was prepared for NFATTC by RMC Research Corporation.

Substance Abuse Prevention

Though newer and less defined than the chemical dependency treatment field, workforce development issues for substance abuse prevention providers are every bit as pressing. In 1998, DASA and the Prevention Subcommittee of the Association of County Human Services sponsored a study "Washington Prevention Professionals: A Profile" that detailed serious concerns related to the field. There is no set collegiate course of study in prevention in Washington State. Most prevention professionals come to the field as second or even third careers. They often do not possess basic information related to theories of prevention, pharmacology, or substance abuse, or the skill set associated with effective performance. Prevention professionals operate very independently from their sponsoring organizations and, in many cases, with limited supervision.

The study indicated that salaries for most prevention professionals are relatively low, averaging just over \$25,000 per

year. Many prevention professionals leave the field for economic reasons. At the same time, the study indicated that prevention professionals report very high job satisfaction.

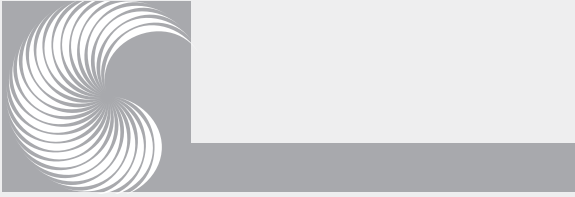
As prevention is a rapidly evolving field, new research findings regarding effective approaches are being published all the time. This presents a serious challenge in trying to ensure prevention professionals are equipped with the best information and skills necessary to do the best possible job.

In collaboration with its prevention providers and partners, DASA is implementing a two-year training development plan. The plan features at its core a weeklong, intensive orientation course called Substance Abuse Prevention Specialist Training (SAPST) developed by the Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies (Western CAPT). The plan calls for offering the course a minimum of six times during the current biennium. In addition, DASA will conduct training-of-trainers workshops twice each year to build training capacity and expand the number of trained prevention providers. DASA is also participating with Western CAPT in the development and design of an advanced training that would focus on developing specific skills needed by prevention professionals.

DASA has been involved in several other key efforts to elevate the professional status of prevention professionals. The first was a comprehensive study of prevention professionals in Washington State that identified and listed the key job activities and tasks they perform. That document, *"A Skill Standard for Substance Abuse and Violence Prevention Professionals,"* was re-published in 2001 and widely distributed.

The second initiative is to actively encourage qualified prevention professionals to seek certification from a national certification body. There presently is no certification requirement in Washington, but Washington State prevention pro-





professionals can obtain certification through other states' certification boards. There is local interest in establishing and maintaining a Washington board.

Finally, DASA has been coordinating with community col-

leges and universities to expand the quantity and quality of prevention classes. So far, at least two new schools will be offering prevention classes in 2002, one of them being an Internet-based, online course that can be taken anywhere in the state.